USD 437

2026

EMPLOYEE BENEFITS GUIDE

Auburn Washburn
Unified School District 437

ELIGIBILITY & ENROLLING

USD 437 is proud to offer you and your eligible family members a comprehensive benefits package. Making well-informed decisions about your benefits is an important part of being a consumer within a challenging health care system. It's also increasingly important to select the right benefits to meet you and your family's needs in order to effectively manage health care services and their costs.

WHO IS ELIGIBLE?

- 12 month employees hired to work 4 or more hours per day
- 9 month employees hired to work 28.75 or more hours per week
- Your lawful spouse
- Dependent child(ren) up to age 26

WHEN DOES COVERAGE BECOME EFFECTIVE?

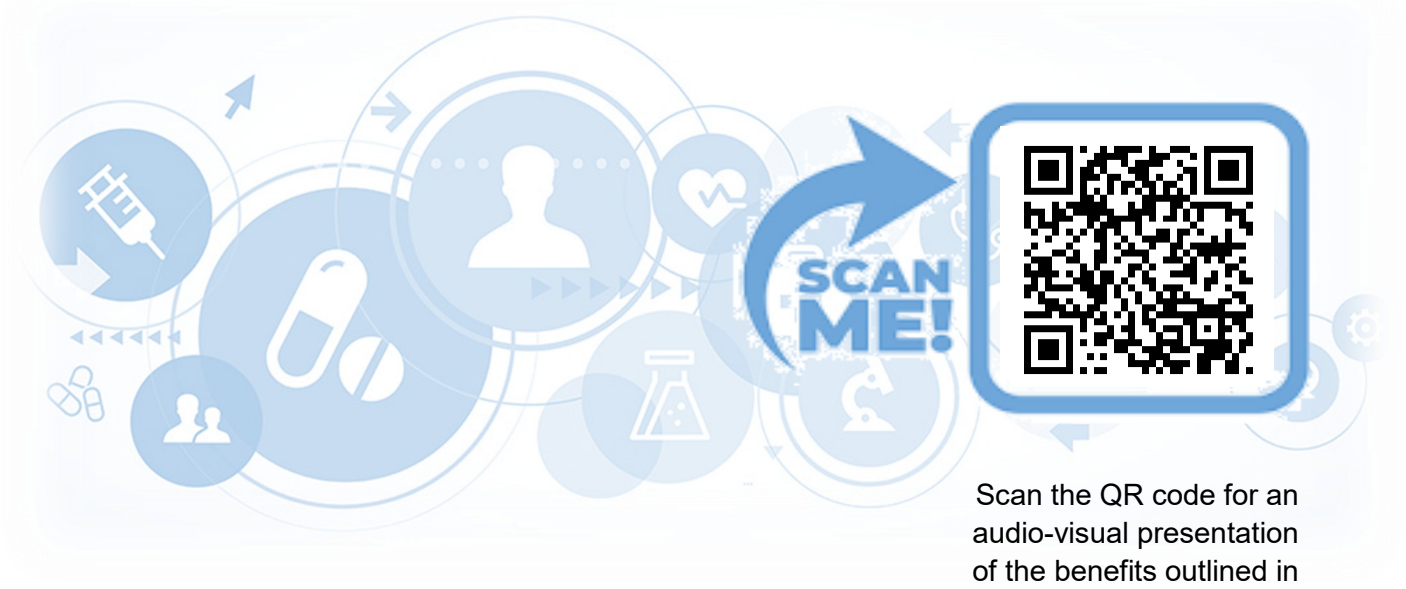
- New hires—first of the month following a 31 day waiting period
- Existing employees—the new benefit period begins **January 1, 2026—December 31, 2026**

HOW TO ENROLL?

New Hires
New Hires will meet with a representative from American Fidelity to make initial benefit elections.

Open Enrollment Elections
All benefit eligible employees can access the American Fidelity self-enrollment portal from November 3 — November 14 at **https://benefits.americanfidelity.com/usd-437-auburn-washburn**.

Once you have made your elections you will **not** be able to change them until the next open enrollment period unless you experience a qualified life event.



Scan the QR code for an audio-visual presentation of the benefits outlined in this benefit guide.

QUALIFYING EVENTS

Premiums for medical, dental, and vision will be deducted from your pay pre-tax. If you fail to elect coverage within the annual open enrollment or new hire eligibility period, you will be deemed to have voluntarily waived eligibility for the respective coverages for the entire year. Once made, pre-tax benefit elections are irrevocable and remain in effect for the plan year unless you have a "Qualified Life Event". Other elective benefits will be paid after tax.

WHEN CAN I MAKE CHANGES?
Generally, you may change your benefit elections only during the **annual open enrollment** period. However, you may change your benefit elections during the year if you experience a qualified life event, including, but not limited to the list below. Any change to your election must be consistent with the life event.

- Marriage
- Divorce
- Birth of your child
- Death of your spouse or dependent child
- Adoption of or placement for adoption of your child
- Change in employment status of employee, spouse or dependent child that causes a change in eligibility for other coverage
- Enrollment in Medicare or Medicaid

PLEASE NOTE:
You must notify the Business office within 30 days of the qualified life event. If you do not contact the Business Office within 30 days of the qualified event, you will have to wait until the next annual enrollment period to make changes (unless you experience another qualified life event). Depending on the type of event, you may be asked to provide proof of the event. **Enrollment forms are due back to the Business office within 30 days of the qualified life event.**

QUALIFIED LIFE EVENT		DOCUMENTATION TO SUBMIT
Dependent loss of the state's CHIP plan	>>	A copy of the Certificate of Creditable Coverage or a termination letter which lists the date coverage ended
Judgement, decree or court order to add coverage for a dependent child	>>	A copy of the court order awarding custody or requiring coverage
Legal marriage	>>	Proof of marriage such as marriage certificate or jointly filed tax return
Birth or adoption	>>	Proof of birth or adoption
Death of your spouse or dependent	>>	A copy of the death certificate
Change in employment status	>>	A copy of the Certificate of Creditable Coverage or a termination letter which lists the date coverage ended

IF YOU (AND/OR YOUR DEPENDENTS) HAVE MEDICARE OR WILL BECOME MEDICARE ELIGIBLE IN THE NEXT 12 MONTHS, A FEDERAL LAW GIVES YOU MORE CHOICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE. PLEASE SEE PAGE 22 FOR MORE DETAILS.

12 MONTH EMPLOYEE PREMIUMS

USD 437 contributes **$673.75** to the medical plan premiums and offers wellness premium incentive(s) to employees enrolled in the medical plan as a continued effort to encourage healthy habits. You have the opportunity to reduce your monthly medical premiums by **$40**.

- Receive **$20** if you are a Non-Nicotine User (must complete a Non-Nicotine Affidavit during Open Enrollment) or participate in an approved Nicotine Cessation program
- Receive **$20** if you complete a Biometric Screening at an onsite event or via your own healthcare provider

MEDICAL			
	Non-Nicotine & Biometric Screening	Non-Nicotine Only OR Biometric Screening Only	No Wellness Participation
Option 1 PPO $1,500			
Single	$203.77	$223.77	$243.77
Employee + Spouse	$1,196.62	$1,216.62	$1,236.62
Employee + Child(ren)	$1,064.82	$1,084.82	$1,104.82
Family	$2,057.67	$2,077.67	$2,097.67
Option 2 HDHP $3,500			
Single	$0.00	$20.00	$40.00
Employee + Spouse	$759.59	$779.59	$799.59
Employee + Child(ren)	$659.01	$679.01	$699.01
Family	$1,418.61	$1,438.61	$1,458.61

DENTAL	
Base Plan	**Monthly Premium**
Single	$35.80
Employee + Spouse	$76.96
Employee + Child(ren)	$69.72
Family	$109.96
Buy Up Plan	**Monthly Premium**
Single	$43.95
Employee + Spouse	$94.52
Employee + Child(ren)	$103.56
Family	$156.93

VISION	
Comprehensive Plan	**Monthly Premium**
Single	$8.76
Employee + Spouse	$18.39
Employee + Child(ren)	$15.75
Family	$29.49
Materials Only Plan	**Monthly Premium**
Single	$9.56
Employee + Spouse	$20.06
Employee + Child(ren)	$17.20
Family	$32.52

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9 MONTH EMPLOYEE PREMIUMS

9-Month employees are eligible to receive the wellness premium incentives as outlined on page 4. As an eligible employee, you have the opportunity to reduce your monthly medical premiums by **$53.34** (**$26.67** per wellness activity). If benefits become effective after January 1st, then your wellness premium incentive(s) will be pro-rated based on your coverage effective date.

NEW HIRES: Deductions will be pro-rated for elections made outside of the open enrollment period.

MEDICAL			
	Non-Nicotine & Biometric Screening	Non-Nicotine Only OR Biometric Screening Only	No Wellness Participation
Option 1 PPO $1,500			
Single	$271.69	$298.36	$325.03
Employee + Spouse	$1,595.49	$1,622.16	$1,648.83
Employee + Child(ren)	$1,419.76	$1,446.43	$1,473.10
Family	$2,743.56	$2,770.23	$2,796.90
Option 2 HDHP $3,500			
Single	$0.00	$26.67	$53.34
Employee + Spouse	$1,012.79	$1,039.46	$1,066.13
Employee + Child(ren)	$878.68	$905.35	$932.02
Family	$1,891.48	$1,918.15	$1,944.82

DENTAL	
Base Plan	**Monthly Premium**
Single	$47.72
Employee + Spouse	$102.61
Employee + Child(ren)	$92.97
Family	$146.62
Buy Up Plan	**Monthly Premium**
Single	$58.61
Employee + Spouse	$126.02
Employee + Child(ren)	$138.09
Family	$209.24

VISION	
Comprehensive Plan	**Monthly Premium**
Single	$11.68
Employee + Spouse	$24.52
Employee + Child(ren)	$21.00
Family	$39.32
Materials Only Plan	**Monthly Premium**
Single	$12.75
Employee + Spouse	$26.75
Employee + Child(ren)	$22.93
Family	$43.36

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MEDICAL PLANS

USD 437 offers medical insurance through Blue Cross Blue Shield of Kansas. You have the option to seek care in or out of network. The benefits illustrated below reflect in-network costs and allowances. Maximum benefits are available when services are received from in-network providers. Blue Choice is the name of the provider network. To find an in-network provider, visit **https://www.bcbsks.com/find-a-doctor/ >** Click on **Find a Doctor/Hospital >** Sign into **BlueAccess®** or choose **Blue Choice Network** if not signed in.

COVERED SERVICES	OPTION 1 PPO	OPTION 2 HDHP
	MEMBER PAYS	
Annual Deductible Individual Two-or-more persons	 $1,500 $3,000	 $3,500 $7,000
Coinsurance *(member portion for most services)*	40% after deductible has been met	
Maximum Out-of-Pocket Individual Two-or-more persons	 $6,350 $12,700	 $6,350 $12,700
Doctor's Office Visits Home & Office Telehealth Urgent Care Preventive Care	 $40 copay Paid at 100% $50 copay Paid at 100%	 subject to ded/coins subject to ded/coins subject to ded/coins Paid at 100%
Drug Coverage—ResultsRx Formulary Mandatory Generics Designated Specialty Pharmacy	**Generic**: $15 copay **Brand**: $100/$200 deductible; then 50% coinsurance **Mail Order Generic:** $37.50 copay **Mail Order Brand:** subject to brand retail ded/coins	Subject to deductible; then 50% coinsurance for Generic, Brand & Mail Order
The quantity per retail prescription is a 30-day supply or 90-day supply for mail order. A 90-day supply is available at a retail pharmacy through the Extended Supply Network.		
Medical Services Emergency Medical Transportation Inpatient Surgery Physician/Surgical Inpatient Facility Fee Outpatient Surgery Physician/Surgical Outpatient Lab and Radiology Advanced Imaging Accidental Injury Services Emergency Room	 subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins $250 copay; then subject to ded/coins	 subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins subject to ded/coins
Recovery/Special Needs Outpatient Rehabilitation Hospice Home Health Care	 subject to ded/coins subject to ded/coins subject to ded/coins	
Mental/Behavioral Health Inpatient* Outpatient	 subject to ded/coins $40 office visit copay	 subject to ded/coins subject to ded/coins
Requires pre-admission certification from **Lucent (formerly New Directions) at 800-952-5906*		

RX, TELEHEALTH & SMARTSHOPPER

PRESCRIPTION DRUG INFORMATION

The **ResultsRx Formulary** consists of a more condensed list of covered medications, insulin drugs are subject to the generic copay (applies to Option 1 only) and compound drugs are excluded.

BCBSKS offers the FlexAccess Copay Assistance Program that takes advantage of manufacturer coupons. When purchasing certain high costing drugs, you will be required or may be automatically enrolled in the drug manufacturers copay assistance program to minimize your out of pocket costs. If you choose not to register with FlexAccess, you may be responsible for your copay without assistance.

Generic medications are mandatory unless your doctor prescribes an override to receive a brand name drug. If no override is provided, you will be responsible for any difference in cost above the copay. For any prescription drugs included on Narrow Therapeutic Index, the member can receive the brand name drug and will not be charged for the cost difference between brand and generic.

The BlueRx Mail program through Express Scripts Pharmacy offers home delivery with the highest standards of quality, safety and service for your prescription drug needs. Call **833-599-0511** or visit:
www.bcbsks.com/prescription-drugs/mail-order

BCBSKS offers the Accredo Specialty Pharmacy Program which benefits members with conditions requiring specialty medications. Your prescription drug benefit may **require** you to use Accredo Specialty Pharmacy to be eligible for benefits. Call **833-721-7620** or use the link below to learn more.
https://www.bcbsks.com/prescription-drugs/specialty

Use the link below to find out if your prescription drug is covered by searching Express Scripts Pharmacy's drug formulary/preferred medication list. Benefits are subject to your specific plan. To get results specific to your coverage, log in to your BlueAccess® account and click on Rx Drugs.
https://www.bcbsks.com/prescription-drugs/drug-list

TELEHEALTH

Blue Cross provides telehealth services through American Well® (Amwell). With Amwell, registration is **FREE**, and the cost per visit (free on Option 1) is less than an emergency room or urgent care visit. It's easy to use, affordable, private and secure. As an innovative patient consultation service, telehealth lets you interact with a doctor at your convenience for common conditions such as cold, flu, fever, sinus infection, rash, etc.

How to Use Amwell

1. Download the Amwell app on any mobile device.
2. On a computer? Visit **www.bcbsks.com/health-and-wellness/telehealth** to get started

Why Use Amwell

- Choose your own physician: select from a list of U.S. board-certified doctor and therapist profiles
- Available nationwide, 24/7/365
- Convenient prescriptions: all prescriptions can be picked up at your local pharmacy
- Easy payment: pay for the visit with credit, debit or HSA/FSA cards.
- Record storage: a complete record of each visit is securely maintained and can be easily accessed

SMARTSHOPPER CASH REWARD PROGRAM

With SmartShopper, you can easily compare convenient, high-quality in-network locations for common medical care and be redirected to the most cost-effective facility of your choice. In addition to lowering costs, you can earn a share of the overall savings as cash rewards of $20—$425.

How to Earn Rewards

1. Login to **Blue Access**
2. Click on the Doctors/Hospitals link
3. Shop for a reward eligible location for your procedure
4. or call the Care Concierge Team at (866) 820-6426 to compare prices and rewards

DENTAL

Dental benefits are offered through **Delta Dental of Kansas**. When you receive services from an in-network provider, you receive deeper discounts on your dental care, meaning you save money on your portion of the cost of services, and your annual maximum goes further. To locate a dentist in-network, download the Delta Dental mobile app, visit **www.deltadentalks.com** or call Customer Service at **800-234-3375**.

COVERED SERVICES (IN-NETWORK)	BASE PLAN	BUY UP PLAN
Annual Deductible (Individual/Family)	$25/$75	$25/$75
Annual Maximum (per covered person)	$1,500	$2,000
Diagnostic & Preventive Care • Oral evaluations - twice per benefit period • Bitewing x-rays - twice per benefit period for dependents under age 18; once each 12 months for adults age 18 and over • Full mouth or panoramic x-rays - once each 5 years • Cleanings - unlimited • Topical fluoride - twice per benefit period for dependents under age 19 • Space Maintainers - for dependents under age 14 • Sealants - once per tooth, per lifetime for dependents under age 16	Covered at 100%	Covered at 100%
Basic Services (subject to deductible) • Ancillary - 1 emergency exam per benefit period for relief of pain • Oral surgery—extractions, pre/post operative care • Fillings • Periodontics • Endodontics - root canal treatments and root canal fillings	Covered at 50%	Covered at 80%
Major Services (subject to deductible) • Crowns • Bridges • Partial and complete dentures	Covered at 50%	Covered at 50%
Orthodontics (subject to deductible) • Dependent children under age 19	No Coverage	Covered at 50%; $1,500 lifetime maximum *(limited to new services only)*

Right Start 4 Kids
Children, **age 18 and under**, receive coverage at **100%** for all services covered under the plan. Not subject to deductible, but the plan's annual maximum and frequencies/limitations apply. Excludes orthodontics. Must see an in-network provider or the plan's underlying contract applies including waiting periods, deductibles and coinsurance levels.

VISION

USD 437 offers vision coverage through Surency to you and your eligible dependents. You have the choice of two different plan options to best suit the needs for you and your family. ***Benefits are available once per calendar year.*** Please refer to the plan document for more detailed benefit information. The benefits illustrated below reflect in-network costs and allowances. To find an in-network provider, visit **www.surency.com**.

COMPREHENSIVE PLAN		
BENEFITS	**IN-NETWORK MEMBER COST**	**OUT OF NETWORK ALLOWANCE**
Exam	$10 copay	$35
Frames	$130 allowance	$65
Standard Lenses Single Vision Bifocal Trifocal Lenticular	 $25 copay $25 copay $25 copay $25 copay	 $25 $40 $55 $55
Lens Options Polycarbonate (age 19 and under) UV Coating Tint (Solid and Gradient) Scratch Resistance Anti-Reflective Coating Standard Progressive Premium Progressive	 $0 $15 $15 $15 $45 $90 $110-$135 (tier 1-3) $120 allowance and 20% off balance (tier 4)	 $25 Not Covered Not Covered Not Covered Not Covered $40 $40 $40
Contact Lens Services & Materials *Allowance not available if eyeglass lenses are elected* Standard Fit & Follow Up Exams Conventional/Disposable Medically Necessary	 $40 copay $130 allowance $0	 $0 $100 $200

MATERIALS ONLY PLAN		
BENEFITS	**IN-NETWORK MEMBER COST**	**OUT OF NETWORK ALLOWANCE**
Frames, Lenses & Options Package *Any frame, lenses, and lens options available at the provider locations*	$200 allowance; 20% off balance over $200	$200
Contact Lenses *Allowance not available if eyeglass lenses are elected*	$200 allowance	$200

ADDITIONAL DISCOUNTS:

- 40% discount off complete pair of eyeglass purchase and 15% off conventional contact lenses
- 15% discount off retail price for Laser Vision correction or 5% discount off the promotional price

FLEXIBLE SPENDING ACCOUNT

A Flexible Spending Account (FSA), also known as a reimbursement account, allows you to pay for a variety of out-of-pocket health care and dependent care expenses pre-tax. Putting money into a FSA before you pay taxes on it saves you money by lowering your taxable income. The result? **You pay less in taxes each year**. There are three types of FSAs available to you at USD 437:

1. **HEALTH CARE FLEXIBLE SPENDING ACCOUNT**. Set aside pre-tax dollars from your paycheck to cover eligible health care expenses such as eyeglasses, contacts, copays, deductibles, prescription medications, and orthodontia. The entire amount you set aside is available to use on the first day of your plan year.
2. **DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT**. Set aside pre-tax dollars from your paycheck to cover eligible dependent care expenses such as day care, babysitting and general purpose day camps for your dependents under the age of 13 while you are at work. You can also use the funds to pay for adult day care services for dependent adults who are unable to care for themselves You will be reimbursed for eligible expenses as they are incurred and as funds are deposited into your account.
3. **LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT**. If you're enrolled in a qualified high-deductible health plan (HDHP) and have an HSA, the IRS limits the expenses for which you may be reimbursed under a health care FSA. You may ONLY participate in a Limited FSA for dental and vision expenses. This account lets you take advantage of the savings power of an HSA and a Healthcare FSA simultaneously. Any funds remaining at the end of the plan year will be forfeited.

INCREASE YOUR TAKE HOME PAY	WITH FSA	WITHOUT FSA
Annual Income	$30,000	$30,000
Pre-tax Contributions	$2,400	$0
Taxable Income	$27,600	$30,000
Taxes (assumes 30% tax bracket)	$8,280	$9,000
Take-Home Pay	$19,320	$21,000
Out-of-Pocket Health Care Expenses	$0	$2,400
Spendable Income	$19,320	$18,600
SAVINGS EACH YEAR	**$720**	**$0**

OTHER POINTS TO REMEMBER...

- You **must** re-enroll in the Flexible Spending Account(s) each year in order to participate
- Up to **$680** in unused funds remaining at the end of the plan year will be carried-over to the next plan year for your Health Care Flexible Spending Account
- Each of these accounts are separate. You can choose to participate in both, one or neither. The rules and regulations of the IRS govern all FSA accounts.

HOW MUCH CAN YOU CONTRIBUTE?

There are limits on the amount you can contribute to FSAs:

- Health Care FSA—annual maximum of **$3,400**
- Dependent Care FSA—annual maximum of **$7,500** ($3,750 if married and filing separate)
- Limited Purpose FSA—annual maximum of **$3.400**

Plan carefully when deciding how much you want to contribute to your account(s) for the year, you have to use your funds by the end of the benefit period or you forfeit the remaining amount (with the exception of the $680 carryover provision for a Health Care FSA). The elections you make will remain in effect until the end of the plan year for any reason unless you experience a qualified event or termination of employment.

HEALTH SAVINGS ACCOUNT

A Health Savings Account (HSA) is a plan designed to help you manage the rising cost of health care by allowing you to set aside money to pay for out-of-pocket medical expenses and to save for retirement. You can think of it as a personal savings account for medical expenses. HSA's are employee-owned, meaning you take the HSA with you if you change employers. Unused funds will earn interest and can be invested until they are withdrawn for eligible expenses or at retirement.

You set aside money on a pre-tax basis—this means as long as you use the money for eligible expenses, you won't pay income taxes on it.

WHO IS ELIGIBLE FOR AN HSA?

- Employees covered by a High Deductible Health Plan (HDHP);
- Employees not covered under another medical plan that is not an HDHP;
- Employees not entitled to Medicare benefits; or
- Employees not eligible to be claimed on another person's tax return.
- Employees who have not received VA benefits in the last 3-months
- Employees not participating in a healthcare FSA account through USD 437 or covered under any other FSA account (i.e. spouse's FSA)

PARTICIPATING IN A HSA IS EASY.

The Health Savings Accounts are administered through **Silver Lake Bank (21st & Urish Branch)**. To set up your account, visit the Business Office or staff website to complete the HSA Application and necessary enrollment forms. **All forms must be returned to the Business Office.**

Once you've enrolled and set your annual election amount, that amount will be automatically taken out of your paychecks in equal increments throughout the year before you pay federal, state, and FICA taxes on that amount of income. Post-tax contributions can also be made as long as it does not surpass the annual max for that year.

Any unused funds in your HSA will roll over at the end of the year and will continue to earn interest and can be invested until they are withdrawn for medical expenses or until you turn 65 years old, when you can withdraw funds for any reason without incurring penalties.

2026 HSA ANNUAL CONTRIBUTIONS	INDIVIDUAL	FAMILY
Annual Maximum Contribution	$4,400	$8,750
Employee Catch-Up Contribution (over age 55)	$1,000	$1,000

WHEN DO I USE MY HSA?

After visiting a physician, facility or pharmacy, your medical claim will be submitted to your HDHP for payment. Your HSA dollars can be used to pay your out-of-pocket expenses (deductibles, coinsurance, copays) billed by the physician, facility or pharmacy, or you can choose to save your HSA dollars for a future medical expense.

SilverLakeBank

LIFE INSURANCE

Term Life Insurance
Term Life Insurance is usually the most affordable type of life insurance. It provides temporary financial protection for your loved ones during your working years. The death benefit pays money directly to your beneficiaries to help with funeral costs and ongoing financial obligations such as daily living expenses, child education and mortgage payments.

Permanent Life Insurance
Permanent life insurance policies do not expire. They are intended to protect your loved ones permanently, as long as you pay your premiums. Some permanent life insurance policies accumulate cash value. That means the value of the policy may grow each year, tax-deferred, until it matches the face value of the policy.

The cash can generally be accessed via loans or withdrawals, and can be used for a variety of purposes. This type of policy is typically portable so coverage can continue if employment terminates. USD 437 offers two permanent life insurance plans—American Fidelity Whole Life and Texas Life Permanent Life.

KPERS Optional Group Life
Benefit eligible employees may purchase KPERS optional group life insurance coverage underwritten by Standard Life Insurance Company. Newly eligible employees are offered the opportunity to enroll within 30 days of hiring. Open enrollment for existing employees is in the month of September.

Plan Features	AF Term Life	AF Whole Life	Texas Life Permanent Life	KPERS Optional Group Life
Portable	✓	✓	✓	✓
Convertible	✓			✓
Cash Value		✓	✓	
Accelerated Benefit	✓			✓
Dependent Coverage	✓	✓	✓	✓

Rates vary based on age, policy type, length of policy, type of policy and dependent type.

SHORT-TERM DISABILITY

If you experience a covered illness or injury, short-term disability can help supplement your income while you are unable to work. USD 437 offers three short-term disability plans to choose from so that you can best meet the needs of your family.

COVERAGE FEATURES	PLAN 1	PLAN 2	PLAN 3
Benefits Begin	1st day injury 8th day sickness	15th day injury 15th day sickness	31st day injury 31st day sickness
Benefit Amount	Not to exceed 70% of monthly salary	Not to exceed 70% of monthly salary	Not to exceed 70% of monthly salary
Benefit Payable	Up to 180 days	Up to 180 days	Up to 150 days
Hospital Confinement	$100 per injury $50 per sickness	$100 per injury $50 per sickness	$300 per injury $50 per sickness
Accidental Death Benefit	10x monthly benefit	10x monthly benefit	$50,000

PRE-EXISTING CONDITION LIMITATION
No disability benefit will be payable if disability is caused by or resulting from a pre-existing condition and begins before you have been continuously covered under the policy for 12 months. This provision will not apply if you have met the criteria below for 12 consecutive months for such condition(s).

⇒ Gone treatment free
⇒ Incurred no expenses
⇒ Taken no medication
⇒ Received no diagnosis or advice from a physician

This limitation will not apply to a disability resulting from a pre-existing condition that begins after you have been continuously covered under the policy for 12 months. Any increase in benefits will be subject to this pre-existing condition limitation. A new pre-existing condition period must be satisfied with respect to any increase applied for and approved by American Fidelity.

There are three optional riders to choose from with the election of short-term disability.

CRITICAL ILLNESS RIDER
Receive a one-time lump sum benefit amount ranging from $10,000—$25,000 based on diagnosis of the following conditions:

- Heart Attack
- Stroke
- Kidney Failure
- Paralysis
- Major Organ Transplant

ACCIDENT ONLY SPOUSAL RIDER
Receive a monthly indemnity amount ranging from $500—$2,000 for your spouse who is disabled as a result of a non-occupational accident. Benefits will begin on the 31st consecutive day after the injury and will continue for up to two years.

HOSPITAL INDEMNITY RIDER
Receive a daily benefit amount ranging from $100—$150 for an inpatient hospital confinement up to a maximum of 90 days.

ACCIDENT

Wellness Benefit	Basic	Enhanced	Enhanced Plus
Annual Routine Physical Exam	$50	$75	$75
Accident Benefit	**Basic**	**Enhanced**	**Enhanced Plus**
Emergency Treatment	$150	$200	$250
Non-emergency Treatment	$75	$100	$125
Medical Imaging (MRI, CT, CAT, PET, US)	$200	$200	$200
Hospital Admission	$500	$1,000	$1,500
Intensive Care Unit	$300	$600	$900
Ambulance (Ground / Air)	$300/$1,500	$300/$1,500	$300/$1,500
Transportation (patient only)	$300	$300	$300
Injury Benefit			
Fracture	$25—$3,000		
Laceration	$25—$400		
Appliances	$100		
Torn Knee Cartilage or Ruptured Disc	$500		
Eye Injury	$50—$250		
Dislocation	$25—$3,000		
Concussion	$200		
2nd & 3rd degree burn	$100—$10,000		
Internal Injury	$1,000		
Paralysis (Paraplegia / Quadriplegia)	$5,000 / $10,000		
Physical Therapy	$25		
Blood, Plasma, and Platelets	$250		
Prosthesis	$500		
Accidental Death & Dismemberment Benefit			
Primary	$1,000 - $50,000	$1,500 - $100,000	$2,000 - $200,000
Spouse	$1,000 - $50,000	$1,500 - $100,000	$2,000 - $200,000
Child	$500 - $25,000	$750 - $50,000	$100 - $100,000
Monthly Premiums	**Basic**	**Enhanced**	**Enhanced Plus**
Employee Only	$19.90	$26.10	$33.40
Employee + Spouse	$28.30	$34.90	$41.90
Employee + Child(ren)	$31.50	$41.00	$51.30
Family	$39.90	$49.80	$59.90

CRITICAL ILLNESS

Surviving a critical illness, such as a heart attack or stroke, may come at a high price. Although many medical plans provide coverage for costs arising from a critical illness, there are still various out-of-pocket expenses that can affect anyone's finances. Copayments, transportation, everyday expenditures, and lost income can add up quickly.

Critical Illness insurance can assist with the expenses that may not be covered by traditional medical insurance. The plan is designed to pay a lump sum benefit amount to help cover expenses if you are diagnosed with a covered critical illness.

You have the option to choose the coverage amount that best suits your needs—a lump-sum benefit of $10,000, $20,000, or $30,000. If elected, spousal benefit amounts will be 50% of the employee benefit amount; and children will be eligible for 25% of the employee benefit amount.

You are also eligible to receive a $50 benefit for a covered health screening test. This benefit features eight qualified tests, including a stress test, echo cardiogram, electrocardiogram (EKG), blood glucose testing, and more.

Covered Illnesses	Benefit Percentage	Recurrent Diagnosis Benefit
Heart Attack	100%	50%
Coronary Artery Bypass Surgery	25%	n/a
Stroke	100%	50%
Paralysis	100%	n/a
Major Organ Failure	100%	50%
End Stage Renal Failure	100%	n/a

PRE-EXISTING CONDITION LIMITATION
No benefit will be payable for a Critical Illness which is caused by or resulting from a Pre-Existing Condition when the Critical Illness Occurrence Date occurs before a Covered Person has been continuously covered under the Policy for 12 consecutive months. Pre-Existing Condition means a disease, accident, sickness, physical condition or mental illness for which a Covered Person has experienced any of the following:

(a) Treatment
(b) Incurred expense
(c) Took medication
(d) Received care or services including diagnostic testing or related measures
(e) Received a diagnosis or advice from a Physician

During the 12-month period immediately before the Covered Person's Effective Date of coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness, physical condition or mental illness.

CANCER

Wellness Benefit	Basic	Enhanced	Enhanced Plus
Preventive & Cancer Screening	$60	$75	$90
Treatment Benefits	**Basic**	**Enhanced**	**Enhanced Plus**
Radiation/Chemotherapy	Up to $15,000	Up to $20,000	Up to $25,000
Medical Imaging	$200	$300	$400
Hormone Therapy	$50	$50	$50
Administrative/Lab work	$75	$100	$125
Blood, Plasma, and Platelets	$150-$7,500	$200-$10,000	$250-$12,500
Bone Marrow/Stem Cell Transplant	$1,000-$3,000	$1,500-$4,500	$2,000-$6,000
Hospitalization Benefit	**Basic**	**Enhanced**	**Enhanced Plus**
Hospital Confinement	$200-$400	$300-$600	$400-$800
Drugs & Medicine	$50-$200	$50-$300	$500-$400
Attending Physician	$40	$50	$60
Transportation & Lodging Benefit	**Basic**	**Enhanced**	**Enhanced Plus**
Ambulance (Ground/Air)	$200/$2,000		
Transportation	Coach fare or $0.50/mile by car		
Lodging (per day)	$60	$80	$100
Surgical Treatment Benefit	**Basic**	**Enhanced**	**Enhanced Plus**
Surgical	$30	$40	$50
Anesthesia	25% of the amount paid for covered injury		
Outpatient Hospital/Ambulatory	$400	$600	$800
Second & Third Surgical Opinion	$300	$300	$300
Continuing Care Benefits	**Basic**	**Enhanced**	**Enhanced Plus**
Prosthesis	$150-$1,500	$200-$2,000	$250-$2,500
Extended Care Facility	$75	$100	$125
Physical or Speech Therapy	$25	$25	$25
Hospice Care	$75	$100	$125
Home Health Care	$75	$100	$125
Medical Equipment	$100	$150	$200

Rates vary by age and type of plan selected. You can view the rates online at https://staff.usd437.net/benefits > Additional Benefits > American Fidelity Cancer Brochure.

Enhance Your Plan

- **Critical Illness rider** pays a lump-sum benefit of $2,500 when diagnosed with internal cancer or heart attack/stroke.
- **Hospital Intensive Care Unit** rider pays a $100 ambulance benefit (per admission in an ICU) and $600

EAP & WELLBEING

EMPLOYEE ASSISTANCE PROGRAM (EAP)
USD 437 is dedicated to the overall well-being of the employees that choose to provide their time and commitment to the children of the communities that the District serves. We understand that life can provide challenges—at home, at work and within the other circles that we choose to be involved in. USD 437 provides you access to resources available through the Employee Assistance Program (EAP) offered through ComPsych, **at no cost to you!**

- **Dedicated Helpline.** 24/7/365 access to licensed behavioral health professionals via a toll-free line.
- **Assessments and Referrals.** Receive guidance to the counseling, health plan, legal, financial and community services you need for any life challenges you face.
- **Short-term Counseling.** For life challenges that are not chronic, you and your family can receive up to six counseling sessions per issue per year for each individual need.
- **Crisis Management Services.** On-site support before, during or after critical situations.
- **GuidanceResources Online.** Online information, resources, tools and other topics such as health & wellness, law & regulations, family & relationships, work & education, money & investments, consumer & leisure and home & auto.
- **FamilySource.** Resources for child and/or elder care in your community. In addition, information is available for automobile purchases, relocation, pet services and apartment shopping.
- **LegalConnect and FinancialConnect.** Legal information and local referrals upon request as well as discounted legal fees in certain areas.

Access your EAP Benefits

- Call into the helpline at **855-784-2054**
- Log into the website at **www.guidanceresources.com** .
  > WebID: **AuburnWashburn**
- App: GuidanceNow

ComPsych®
— The GuidanceResources Company® —

EMPLOYEE WELLBEING PROGRAM
The mission of the Employee Wellbeing Program is to encourage, promote, and support wellbeing for every employee, every day. Our vision is to encourage and promote healthy living by providing a caring, supportive environment where healthy behaviors can be modeled, developed, and sustained for staff and students alike. All district employees are eligible to take part in the wellbeing initiatives.

Employee Wellbeing Website: **http://usd437employeewellness.weebly.com**

Wellbeing Programs & Services

- Exercise Prescriptions
- Nutritional Consulting
- Wellness Consulting
- Wellbeing Incentive Challenges
- National Health Observances
- Health Presentations
- Work Station Assessment
- Wellbeing Fair
- District Fitness Options
- Integrated Wellbeing Website

Auburn-Washburn
Employee Wellbeing

403(B) RETIREMENT

USD 437 provides employees the opportunity to invest in a 403(b) account through payroll deductions. Bay Bridge Administrators manage all aspects of the program including monthly remittance, activity monitoring, and compliance. For more information you can access the USD 437 staff website or the BBA website at www.bbadmin.com/retirement > Plan Information for Current Members > Employees > Select your state > Select your employer. Below is the list of approved investment providers to choose from:

American Fidelity Assurance Company
Ameriprise Financial Services
AXA Equitable Life Insurance
Brighthouse Life Insurance
Fiduciary Trust So. Of New Hampshire
MetLife Resources
North American Company for Life & Health Insurance
Aspire Financial Services
Cetera Advisor Networks
Primerica Shareholder Services
OFG Financial Services
Thrivent Financial
Valic
Voya Retirement Insurance & Annuity-Ease

In order to invest in a 403(b) account you will need to complete a Salary Reduction Agreement (SRA) and/or Election Form. The SRA can be found on the Bay Bridge Administrators website or requested from the Business Office. Current plan participants will receive a personalized election form from the Business Office. See below to determine which forms are necessary for you to complete and return to the Business Office.

- ⇒ Setting up a New Account > Complete a SRA > **Return to Business Office for Processing**
- ⇒ Existing Account Holder not making changes > **Complete Business Office Election Form**
- ⇒ Existing Account Holder making changes > **Complete Business Office Election Form & SRA**

BAY BRIDGE ADMINISTRATORS
"Your solutions begin at the Bridge"®

LEGAL NOTICES

NO SURPRISES ACT

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise or balance billing. You are only responsible for paying your share of the cost that you would pay if the provider or facility was in-network. Additionally, you are never required to give up your protections from balance billing and not required to get care out-of-network.

CONTINUATION OF HEALTH PLAN COVERAGE

A federal law, commonly referred to as COBRA (for Consolidated Omnibus Budget Reconciliation Act) gives you and your covered dependents the right to continue health plan coverage in certain circumstances when it would otherwise end. These include termination of employment or reduction in hours causing loss of plan eligibility of the covered employee, as well as for covered dependents, the death of the covered employee, a divorce or legal separation from the covered employee, or ceasing to be an eligible dependent child of the employee.

It is very important that you notify Human Resources if you experience a divorce/legal separation or have a dependent who no longer meets the eligibility rules of the plan.

If you do not notify Human Resources of one of these events within 60 days, your covered dependents will lose the right to continue their coverage under COBRA. More details are available in the COBRA notification material sent to new health plan participants.

NOTICE OF SPECIAL ENROLLMENT PROVISIONS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health plan coverage, you may in the future be able to enroll yourself and/or your dependents in this plan, provided that you request enrollment within 30 days after you or your dependents lose eligibility for that other coverage (or employer contributions toward that coverage end). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment, contact your Human Resources Department.

HIPAA PRIVACY

The USD 437 medical plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about the uses of protected health information (PHI) and your privacy rights. PHI use and disclosure by the USD 437 medical plan is regulated by federal law known as HIPAA (the Health Insurance Portability and Accountability Act). A paper copy may be requested through the Human Resources Department.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you had or are scheduled to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights of 1998. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined, in consultation with attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Treatment of physical complications during all stages of the mastectomy, including lymphedemas
- Prostheses

These benefits will be provided, subject to the same deductible, copays, and coinsurance applicable to other medical and surgical benefits under the plan.

SPECIAL RULES FOR MOTHERS AND NEWBORNS

Group health plans and health insurance issuers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours or (96 hours).

LEGAL NOTICES

NOTICE OF CHIPRA POLICY MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS - NOW or www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660

For additional state information or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Option 4, Ext. 61565

HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE
PART A: General Information *(Form Approved OMB No. 1210-0149—Expires 12-31-2026)*
Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on My Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage an may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.96% of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.96% of the employee's household income. **Note:** If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

LEGAL NOTICES

When Can I Enroll in Health Insurance Coverage through the Marketplace?
You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.
There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.** Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer
This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information.

Employer Name:	USD 437 Auburn Washburn
Employer EIN:	48-0722041
Employer Address:	5928 Southwest 53rd St. | Topeka, KS | 66610
Employer Phone:	(785) 339-4000
Contact Person:	Shannon Thoele | thoelsha@usd437.net | (785) 339-4014

Here is some basic information about health coverage offered by this employer:

- We offer a health plan to:
  - ◊ 12 month employees regularly scheduled to work four (4) or more hours per day
  - ◊ 9 month employees regularly scheduled to work 28.75 or more hours per week
- We offer coverage to eligible spouses and dependent children to age 26
- This coverage is intended to meet the minimum value standard, and the cost of this coverage to you is meant to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount. If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

LEGAL NOTICES

IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with USD 437 and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice. There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. BCBSKS has determined that the prescription drug coverage offered by USD 437 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore, considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current USD 437 coverage will not be affected. You may keep your USD 437 coverage and this plan may coordinate with Part D coverage. In addition, your current coverage pays for other health expenses, in addition to prescription drugs, and you will still be able to keep these important benefits if you choose to enroll in a Medicare prescription drug plan. If you do decide to join a Medicare drug plan and drop your current USD 437 coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with USD 437 and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage:

Contact Human Resources at (785) 339-4014. NOTE: You will receive this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through USD 437 changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage:

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1-800-772-1213 (TTY 1-800-325-0778)**.

Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

CONTACT INFORMATION

CARRIER CONTACTS		
Blue Cross Blue Shield of Kansas *Medical & Rx*	www.bcbsks.com	800-432-3990
Delta Dental *Dental*	www.deltadentalks.com	800-234-3375
Surency *Vision*	www.surency.com	866-818-8805
American Fidelity *Flexible Spending Account, Life, Disability, Accident, Critical Illness, & Cancer*	www.americanfidelity.com	800-662-1113 Topeka Branch 785-232-8100
Silver Lake Bank (21st & Urish Branch) *Health Savings Account*	www.silverlakebank.com	785-290-2270
ComPsych-Guidance Resources *Employee Assistance Program (EAP)*	www.guidanceresources.com WebID: **AuburnWashburn**	855-784-2054
Bay Bridge Administrators *403 (b) Retirement*	www.bbadmin.com/retirement	800-845-7519
BENEFIT SPECIALIST		
Brown & Brown	Lanora Graves lanora.graves@bbrown.com	316-448-5110
USD 437 AUBURN WASHBURN		
Wellbeing & Benefits Coordinator	Shannon Thoele—thoelsha@usd437.net	785-339-4014

If you are eligible for Medicare, choosing between a Medicare plan and your employer sponsored medical plan can be overwhelming. Below is a resource to help you research, compare and purchase Medicare insurance plans:

MEDIQUEST PLUS, LLC
Mediquestplusllc.com
Julie Lampe | jlampe@mediquestplusllc.com
(316) 305-8955
(855) 900-5482 | TTY: 711

Inspiring, Challenging, and Preparing

EVERY CHILD, EVERY DAY

DISCLAIMER:

This Benefits Resource Guide is designed to provide basic information regarding benefit plans and programs available to eligible employees. This document merely summarizes the employee benefit plans and programs and does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts and/or Summary Plan Descriptions (SPD) (the "plan documentation") for the various benefit plans and programs. Every reasonable effort has been made to ensure the accuracy of the information contained in this document; however, in the event of a discrepancy between the information in this document and the plan documentation, the provisions described in the plan documentation will govern. This document does not create any contractual rights for any current or former employee of USD 437, or for any other individual. The provisions of the applicable plan documentation will govern the determination of any individual's rights under any employee benefit plan or program. Your employer reserves the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.

Brown & Brown